Eliminating Lifetime and Annual Limits

- All health plans are prohibited from putting a lifetime dollar limit on "essential" covered benefits.
- The Act phases out annual limits for "essential benefits" for all plans except "grandfathered" individual health insurance policies by specifying that none of them can set an annual dollar limit on most benefits lower than:
- \$750,000 for a plan year or policy year starting on or after September 23, 2010 but before September 23, 2011.
- \$1.25 million for a plan year or policy year starting on or after September 23, 2011 but before September 23, 2012.
- \$2 million for a plan year or policy year starting on or after September 23, 2012 but before January 1, 2014.
- No annual dollar limits are allowed on most covered benefits beginning on January 1, 2014.

- fact Health plans can put an annual dollar limit and a lifetime dollar limit on spending for health benefits that are not "essential health benefits" as defined in the law.
 - Some plans or policies may be eligible for a waiver from rules concerning restricted annual dollar limits. To find plans granted waivers see: hss.gov/ociio/regulations/patient/appapps.html

Health Plan Appeals and Grievances

- Health plan consumers have the right to file a grievance/appeal when the plan refuses to pay for a treatment or service. Providers play an important role in this process (see section below).
- Appeals must have a response time as follows:
- 72 hours for denials of urgent care.
- 30 days for denials of non-urgent care not yet received.
- 60 days for denials of service already received.
- If the health plan still denies the benefit, information about how consumers can ask for an external review must be provided.
- External appeals must be filed within 120 days of getting written notice from the consumer's health plan that they have exhausted all of the plan's internal appeals processes.

Provider's Role in the Appeal Process

- Provider's records are an important part of an appeal for a treatment, service or benefit.
- Providers can help patients have a more effective appeal by writing a letter to the health plan explaining why a procedure, service or treatment is medically necessary for their patient.
- In some cases, providers may phone the health plan for an appeal or may be asked to attend an external review on their patient's behalf.
- For copies of the External Appeal Consumer Guide and the External Appeal Application call the CT Insurance Department at 860.297.3910.
- Providers can refer their patients to the Office of the Healthcare Advocate to get help with the appeals process.

fact • Health plan consumers who do not speak English may be able to get appeals information in their native language.



Office of the Healthcare Advocate STATE OF CONNECTICUT

There's help. Call 1.866.HMO.4446

A free service of the State of Connecticut.

www.ct.gov/oha







 understanding provisions under the affordable care act

Young Adult Children Can Join or Stay on Their Parent's Plan Until Age 26

Adult children under age 26 can join or remain on their parent's health plan whether or not they are:

- Married;
- Living with their parents;
- In school;
- Financially dependent upon their parents;
- Eligible to enroll in their employer's plan, with one temporary exception: Until 2014, "grandfathered" group plans do not have to offer dependent coverage up to age 26 if that young adult is eligible for group coverage outside of their parent's plan.
- "Grandfathered" plans are exempt from certain provisions of the law. If an employment-based health plan or individual healt insurance policy was in existence or purchased on or before March 23, 2010 some provisions of the new law do not apply. The health plan's policy must disclose in its plan materials whether it considers itself to be grandfathered and must also

To Learn More: ct.gov/oha – under Resources or healthcare.gov To Get Help: Call the Office of the Healthcare Advocate: 1.866.HMO.4446

Children Under Age 19 Get Protection

- Health Plans can no longer exclude, limit or deny benefits to a child younger than age 19 because the child had a pre-existing condition before they applied for coverage.
- This rule starts as soon as a person's plan begins a new "plan year" or "policy year" on or after September 23, 2010.

fact • This rule does not apply to "grandfathered" individual health insurance policies bought on or before March 23, 2010.

• These benefits will be extended to all Americans of all ages, with pre-existing conditions starting in 2014.

Preserving Doctor Choice and Ensuring Emergency Care

- Health plan consumers are guaranteed the right to choose the primary care doctor or pediatrician they want from their health plan's provider network.
- Health plan consumers do not need a referral to see an OB-GYN.
- Consumers can access out-of-network emergency rooms-Health plans cannot charge higher cost-sharing (co-payments or co-insurance) for emergency room services obtained out of a plan's network.
- Consumers may still be responsible for the difference between the amount billed by the provider for out-of-network emergency room services and the amount paid by the health plan.

fact • These rules do not apply to "grandfathered" health plans

 If your plan is not "grandfathered", these rights start when the consumer starts a new plan year or policy year on or after September 23, 2010.





Access to Affordable Preventive Care Services

- Health plan consumers who have policies created after March 23,2010 have access to key preventive services without being charged a co-payment, co-insurance, or deductible when using in-network providers.
- Some of the services include:
 - Blood pressure, diabetes, and cholesterol tests
 - Many cancer screenings, including mammograms and colonoscopies
 - Counseling on such topics as quitting smoking, losing weight, eating healthfully, treating depression and reducing alcohol use
 - Routine vaccinations against diseases such as measles, polio or meningitis
 - Flu and pneumonia shots
 - Counseling, screening, and vaccines to ensure healthy pregnancies
 - Regular well-baby and well-child visits, from birth to age 21

†act • Employer-based or individual health plans that existed or were purchased on or before March 23, 2010 are "grandfathered" from the provision.

If the "preventive" service is not the main reason for the office visit, the health plan may ask consumers to pay a part of that office visit.

Consumers may have additional rights under Connecticut law. Please call OHA for help in determining whether your patient has Connecticut-based healthcare rights.

